Optional State Assessment
Version 1.0

Effective 10/1/2023

OSA Manual, Item Set and Change History:

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

Downloads

Final OSA Manual_Item Set_Change History_October_1_2023 (ZIP)

Instructions for other OSA items

- Instructions for completing other items on the OSA can be found in the respective sections of Chapter 3 of the Minimum Data Set (MDS) *Resident Assessment Instrument (RAI) 3.0 User's Manual*.
- The guidance in the OSA Manual should only be applied when completing an OSA for payment purposes.
- Providers should use the guidance in the MDS *RAI 3.0 User's Manual* to guide their completion of Federally required assessments.
- OSA-1

OSA

A0300: Optional State Assessment

A0300. Optional State Assessment

Enter Code: 1

A. **Is this assessment for state payment purposes only?**
0. **No**
1. **Yes**

Enter Code: 5

B. **Assessment type**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

Item Rationale

- Allows for collection of data required for state payment reimbursement.

Coding Instructions for A0300, Optional State Assessment

- Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.
- If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.

OSA: A0300

Coding Tips

• This assessment is not Federally required; however, it IS required by North Carolina.

• This must be a standalone assessment (i.e., cannot be combined with any other type of assessment).

• The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes.

• If your state requires this record for state payment purposes, enter a value of “1” (Yes) and proceed to item A0300B, Assessment Type.

A0410

A0410. Unit Certification or Licensure Designation

Enter Code

3

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

A1005: Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin?
A1010: Race: What is your race?
Check all that apply

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

Check all that apply

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

A1010. Race
What is your race?

Check all that apply

- ☐ **A.** White
- ☐ **B.** Black or African American
- ☐ **C.** American Indian or Alaska Native
- ☐ **D.** Asian Indian
- ☐ **E.** Chinese
- ☐ **F.** Filipino
- ☐ **G.** Japanese
- ☐ **H.** Korean
- ☐ **I.** Vietnamese
- ☐ **J.** Other Asian
- ☐ **K.** Native Hawaiian
- ☐ **L.** Guamanian or Chamorro
- ☐ **M.** Samoan
- ☐ **N.** Other Pacific Islander
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond
- ☐ **Z.** None of the above

Steps for Assessment (Combined A1105 & A1010)

1. Ask the resident to select the category or categories that most closely correspond to the patient's race & ethnicity from the list in A1005, Ethnicity & A1010, Race.

• Individuals may be more comfortable if this and the subsequent question are introduced by saying, "We want to make sure that all our patients get the best care possible, regardless of their racial or ethnic background. We would like you to tell us your ethnic/racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care"

2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative
3. Ethnic/Race category definitions are provided only if requested in order to answer the item.
4. Respondents should be offered the option of selecting one or more ethnic designations.
5. Only use medical record documentation to code Ethnicity/Race if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).

A1600 through A2400

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month - Day - Year

A1900. Admission Date (Date this episode of care in this facility began)

Month - Day - Year

A2300. Assessment Reference Date

Observation end date:

Month - Day - Year

A2400. Medicare Stay

B. Start date of most recent Medicare stay:

Month - Day - Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

Section B: Hearing, Speech, and Vision

Look back period for all items is 7 days unless another time frame is indicated

Section B - Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0700, Makes Self Understood
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression

0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0700: Makes Self Understood

- This item cannot be coded as Rarely/Never understood if the resident completed any of the resident interviews. As the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make them self understood during the entire 7 day look back.
- This includes the ability to express or communicate requests, needs, opinions and to conduct social conversations in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make oneself understood can included reduced voice volume and difficulty in producing sounds, finding the right word, making sentences, writing and/or gesturing.
- This should be coded after 11:59 PM of the ARD, taking into account all information.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

Cognitive Patterns

Section C - Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code ☐

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code ☐

A. Able to report correct year

1. **Missed by > 5 years** or no answer
2. **Missed by 2-5 years**
3. **Missed by 1 year**
4. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code ☐

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code ☐

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

Cognitive Patterns

Section C - Cognitive Patterns

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code ☐

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Code ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to D0100, Should Resident Mood Interview be conducted?
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Section C: Cognitive Patterns

- C0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's preferred language or primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the assessment should have been done during the look back period and *WAS NOT*, code C0100 as YES and dash (-) the information.
- C0500: Enter "99" if the resident was unable to complete the interview, do not dash.
- Score: 13- 15 cogitatively intact, 8-12 moderately impaired, 0-7 severely impaired.

*Need documentation of examples

Section C (continued)

- C0600: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.
- *DO NOT* complete a staff assessment if the resident interview *should have* been done and was not.
- C1310: Signs and Symptoms of Delirium: This may alert you to a problem. Probe and document what was said, then make a decision about notifying the physician.

Section C Coding Tips from page C-2

- Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

Mood

Section D - Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

Resident Mood Interview

D0200: Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About* **how often** *have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes↓	
A.	***Little interest or pleasure in doing things***	☐	☐
B.	***Feeling down, depressed, or hopeless***	☐	☐
C.	***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D.	***Feeling tired or having little energy***	☐	☐
E.	***Poor appetite or overeating***	☐	☐
F.	***Feeling bad about yourself - or that you are a failure, or have let yourself or your family down***	☐	☐
G.	***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H.	***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I.	***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

Staff Assessment of Resident Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that they feel bad about self, are a failure, or have let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 30.

Section D: Mood

- D0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. DO NOT consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the resident refuses, make several attempts.
- If the assessment should have been done during the look back period and WAS NOT, code D0100 as YES and dash (-) the information.

Section D (continued)

- D0200: Symptom presence and frequency may alert you to a problem. Probe and document what was said during the interview. Then make a decision to notify the physician or not.
- D0200 I: Thoughts that would be better off dead- you must ask this question. If yes, find out why. Feeling ready to die is not the same as better off dead.
- D0300 Total Severity Score: 1-4 Minimal depression, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe depression.

Section D (continued)

- D0500: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.
- DO NOT complete a staff assessment if the resident interview should have been done and was not.

D0200 Resident Mood Interview

Coding Instructions

• The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©.

• If symptom frequency is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as "99" and the **Staff Assessment of Mood** should be conducted.

• Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or "**99**" if symptom frequency is blank for 3 or more items).

• The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see the PHQ-9© Resident Mood Interview Total Severity Score Scoring Rules following this section.

OSA-9

Behavior

E0100. Potential Indicators of Psychosis

Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Enter Code ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)

Enter Code ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)

Enter Code ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Has the resident wandered?

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Section E: Behavior

- This section is based on observations during the look back period.
- An increase in behaviors should be discussed with the physician, consider PASRR notification, or a possible SCSA.
- Should seek to understand why the behavior is being exhibited: lonely, meaningless, helpless, boredom.

*Need documentation of dates and behaviors.

Section E (continued)

- E0800 Rejection of Care: If the resident understands the ramifications of the lack of care, this would not be rejection.
- When surveyors look at ADL care, facial hair, long nails, the rejection of care section of the MDS is also reviewed.
- E0900 and E1000: Wandering. If the resident is out of the building without staff knowledge=elopement.
- Not talking about alert and oriented who have been assessed as safe to go outside. Or confused residents who are allowed to wander into an enclosed, secured area.
- If the resident has exit seeking behaviors, and this was prior knowledge, the facility is liable.

OSA Section G

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. **ADL Self-Performance**
   Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. **ADL Support Provided**
   Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐

Section G:
Functional Status

- Items in this section assess the need for assistance with activities of daily living, altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.
- Start updating care plans and training staff with GG language.

G0110: ADL Assistance Definitions

- Self performance
- Code 0, Independent: If resident completed activity with no help or oversight every time during the 7-day look-back period and it occurred at least 3 times.
- Code 1, Supervision: If oversight, encouragement, or cueing was provided 3 or more times in the last 7 days.
- Code 2, Limited assistance: If resident was highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times in the last 7 days.

G0110: ADL Assistance Definitions (continued)

- Code 3, Extensive assistance: If the resident performed part of the activity over the last 7 days and help of the following type (s) was provided
- Weight-bearing support provided 3 or more times
- OR
- Full staff performance of an activity 3 or more times during part but not all of the last 7 days.

G0110: ADL Assistance Definitions (continued)

- Code 4, Total dependence: If every time it occurred there was full staff performance of an activity with no participation by resident for *any* aspect of the ADL activity, and the activity occurred 3 or more times.
- Code 7, Activity only occurred once or twice: If the activity occurred fewer than 3 times in the last 7 days.
- Code 8, Activity did not occur: If the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

Section G: ADL Assistance Coding Tips

- Observations, record review, and interview all shifts.
- Do not code ADLs based on the resident's potential ability, but on actual performance.
- Include only assistance provided by individuals employed or under contract with the facility (no family, students, visitors or Hospice staff).
- Consider each episode of an activity that occurred during the 7 day look back period.

Coding Tips and Special Populations

- Some residents are transferred between surfaces including to and from the bed, and wheelchair by staff, using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer. Total assistance.
- Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as extensive assistance, as the resident participated in the transfer and the lift provided weight-bearing support.

Coding Tips and Special Populations

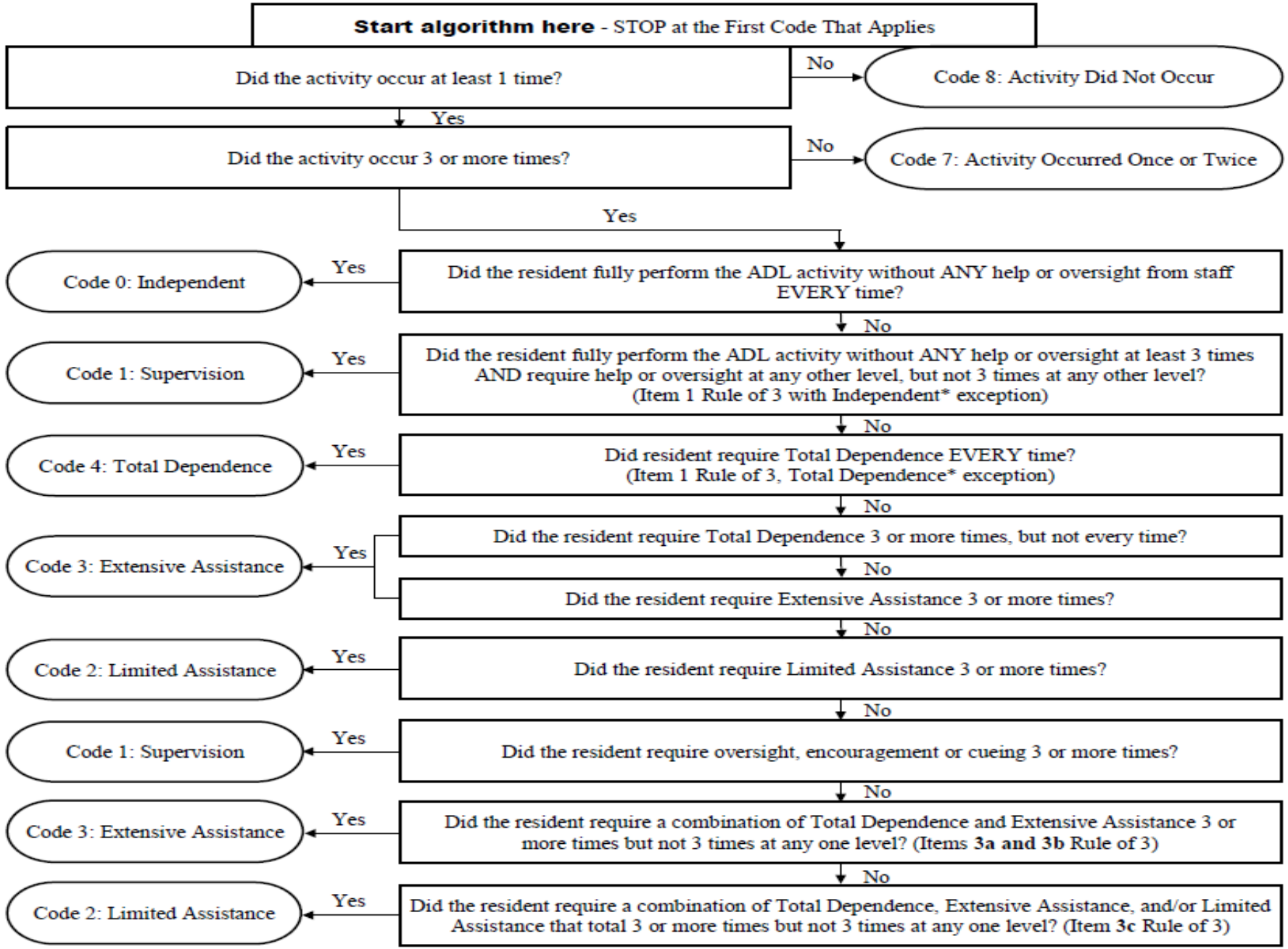
- How a resident turns from side to side, in the bed, during incontinence care, is a component of bed mobility and should not be considered as part of Toileting.
- When a resident is transferred into or out of bed or a chair for incontinent care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.

Coding with the Rule of 3

- Staff completing this section must understand the ADL self performance coding level definitions, the components of each ADL, and the steps to the rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, that type and what level of support was required for each ADL activity over the entire 7-day look-back period.

Activities of Daily Living Definitions

- **A. Bed mobility:** how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.
- **B. Transfer:** how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).
- **H. Eating:** how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).
- **I. Toilet use:** how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.
- OSA-17


Start algorithm here - STOP at the First Code That Applies
Did the activity occur at least 1 time?
No
Code 8: Activity Did Not Occur
Yes
Did the activity occur 3 or more times?
No
Code 7: Activity Occurred Once or Twice
Yes
Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?
Yes
Code 0: Independent
No
Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)
Yes
Code 1: Supervision
No
Did resident require Total Dependence EVERY time? (Item 1 Rule of 3, Total Dependence* exception)
Yes
Code 4: Total Dependence
No
Did the resident require Total Dependence 3 or more times, but not every time?
Yes
Code 3: Extensive Assistance
No
Did the resident require Extensive Assistance 3 or more times?
Yes
Code 2: Limited Assistance
No
Did the resident require Limited Assistance 3 or more times?
Yes
Code 1: Supervision
No
Did the resident require oversight, encouragement or cueing 3 or more times?
Yes
Code 3: Extensive Assistance
No
Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level? (Items **3a and 3b** Rule of 3)
Yes
Code 2: Limited Assistance
No
Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item **3c** Rule of 3)

Exceptions to the Rule of 3

- Code 0- Independent
- Code 4- Total dependence
- Code 8- Activity did not occur
- The definition for these coding levels are finite and cannot be entered on the MDS unless that level occurred every time the ADL occurred.
- Code 7- Activity occurred only once or twice. Coded in the ADL activity occurred fewer than 3 times in the 7-day look-back period.

OSA Section H

Section H - Bladder and Bowel

H0200. Urinary Toileting Program

Enter Code ☐

C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

0. **No**
1. **Yes**

Toileting Programs

- Toileting programs must include:
- Evidence it was used during the look back period.
- Must be individualized, resident specific, based on an assessment.
- Evidence it had been communicated to the staff and the resident.
- Would expect to see flow records, a care plan and written evaluations of the resident response.
- This would include toileting trials.
- Guidance found in RAI Appendix C.

Active Diagnoses

Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Infections		
☐	I2000.	Pneumonia
☐	I2100.	Septicemia
Metabolic		
☐	I2900.	Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
Neurological		
☐	I4300.	Aphasia
☐	I4400.	Cerebral Palsy
☐	I4900.	Hemiplegia or Hemiparesis
☐	I5100.	Quadriplegia
☐	I5200.	Multiple Sclerosis (MS)
☐	I5300.	Parkinson's Disease
Pulmonary		
☐	I6200.	Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
☐	I6300.	Respiratory Failure
None of Above		
☐	I7900.	None of the above active diagnoses within the last 7 days

Section I: Active Diagnoses

- The items in this section are intended to code diseases and conditions that have a direct relationship to current function, cognition, moods, behaviors, medical treatment, nursing monitoring, or risk of death.
- One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.
- This section identifies active diseases and infections that drive the current care plan.
- Diagnoses need to have been noted by the physician within the past 60 days, and then narrow to the last 7 days if active (labs, monitoring, medications, therapy).

Section I: Active Diagnoses

- I5100 Quadriplegia. No functional use of all four limbs. Use only if spinal cord injury. Spinal cord injury must be a primary condition and not a result of another condition. DO NOT code functional quad here. If the resident has dementia or spastic quadriplegia due to cerebral palsy, stroke, contractures, brain disease the primary diagnosis should be coded and not the resulting paralysis or paresis from that condition.

Section J

Section J - Health Conditions

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- ☐ C. Shortness of breath or trouble breathing when lying flat
- ☐ Z. None of the above

J1550. Problem Conditions

↓ Check all that apply

- ☐ A. Fever
- ☐ B. Vomiting
- ☐ C. Dehydrated
- ☐ D. Internal bleeding
- ☐ Z. None of the above

Section J: Health Conditions

- The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of shortness of breath and problem conditions.
- Documentation is needed to justify answers.

J1100 Shortness of Breath

- **Steps for Assessment**
- Interview the resident about shortness of breath.
- If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.
- Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing.
- Observe the resident for shortness of breath or trouble breathing.
- If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

J1550 Other Health Conditions

A. Fever

Defined as 2.4 degrees Fahrenheit higher than baseline. A temp of 100.4 F on admission is considered a fever. Important to obtain baseline temperature

B. Vomiting

C. Dehydrated

Check if resident with 2 or more potential indicators: <1500 ml/day intake, dry mucus membranes, poor skin turgor and diagnosis, cracked lips, sunken eyes, abnormal labs, fluid loss (V, D, F)

D. Internal Bleeding

Do not include controlled nose bleeds, menses, UA with small blook. May include hematoma or ICH if can be proved it occurred during the lookback period.

Z. None of the above

Swallowing Nutritional Status

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
Z. None of the above	☐	☐

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	3. During Entire 7 Days
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	Enter Code ☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	Enter Code ☐

Section K: Swallowing/Nutritional Status

- K0300 Weight Loss: Since this looks back 6 months, it may not capture weight loss from 3 months ago. If weight loss has been recognized and the resident has already regained some weight this would still need to be addressed. Explain in the CAA or the resident's record.
  - This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

K0300: Weight loss

- Physician Prescribed Weight-loss Regimen
- A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight-loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.
- To code K0300 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.

K0510A: Parenteral/IV Feeding

- Include only if given for nutrition or hydration and when there is documentation addressing the need.
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy

Section K (continued)

- K0510 Nutritional Approaches:
  - Column 1, items A, B and Z are required information in North Carolina.
- K0510 A Parenteral/IV feeding: Needs documentation that reflects the need for additional fluids to address nutrition, hydration or prevention.
- K0510B Feeding tube: Only mark this if used for nutrition or hydration.
- K0710 A&B: Code only if K0510 A or B column 1 and/or2 are checked. Documentation is necessary to justify coding.

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this resident have one or more unhealed pressure ulcers/injuries?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number ☐

A. **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

1. **Number of Stage 1 pressure injuries**

Enter Number ☐

B. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. **Number of Stage 2 pressure ulcers**

Enter Number ☐

C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers**

Enter Number ☐

D. **Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. **Number of Stage 4 pressure ulcers**

Enter Number ☐

F. **Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**

Section M Skin Conditions

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ Enter the total number of venous and arterial ulcers present

M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply

Foot Problems

- ☐ A. **Infection of the foot** (e.g., cellulitis, purulent drainage)
- ☐ B. **Diabetic foot ulcer(s)**
- ☐ C. **Other open lesion(s) on the foot**

Other Problems

- ☐ D. **Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- ☐ E. **Surgical wound(s)**
- ☐ F. **Burn(s)** (second or third degree)

None of the Above

- ☐ Z. **None of the above** were present

M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

- ☐ A. **Pressure reducing device for chair**
- ☐ B. **Pressure reducing device for bed**
- ☐ C. **Turning/repositioning program**
- ☐ D. **Nutrition or hydration intervention** to manage skin problems
- ☐ E. **Pressure ulcer/injury care**
- ☐ F. **Surgical wound care**
- ☐ G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
- ☐ H. **Applications of ointments/medications** other than to feet
- ☐ I. **Application of dressings to feet** (with or without topical medications)
- ☐ Z. **None of the above** were provided

Section M: Skin Conditions

- If a Pressure Ulcer heals on or before the ARD, it is not captured.
- Wounds do not heal in reverse. Page M-7 discusses backstaging.
- M0300E: Unstageable-Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Only code with supporting documentation in the record.
- If a wound was present upon admission, then becomes unstageable, or at a higher stage, then new category was NOT present upon admission.

Section M (continued)

- M1040 D Open lesion(s) other than ulcers, rashes, cuts: that are not coded elsewhere and develop as a result of a disease process should be coded here.
- Cuts, lacerations, and abrasions are not coded on the MDS.
- M1040 H Moisture Associated Skin Damage (MASD): Superficial skin damage. If MASD if present with a PU, only code the pressure ulcer. If the tissue damage extends into the subcutaneous tissues, then code as a pressure ulcer.

Section M (continued)
M1200 Skin and Ulcer/Injury Treatments

- M1200 H Applications of ointments/medications other than to feet: Includes barrier creams and skin prep.
- Skin prep to the heel for prevention is not captured on the MDS.
- If skin prep is being used on the heel to treat a DTI, code at M1200 E, Pressure ulcer/injury care.
- Band aids are not coded as dressings.

Kennedy Terminal Ulcers

Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers

(KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

Section N Medications

Section N - Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to O0100, Special Treatments, Procedures, and Programs

N0350. Insulin

Enter Days ☐ A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

N0350: Insulin

Coding Tips and Special Populations

• For sliding scale orders:

— A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

— If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.

• For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

Section O Special Treatments, Procedures, Programs

Section O - Special Treatments, Procedures, and Programs

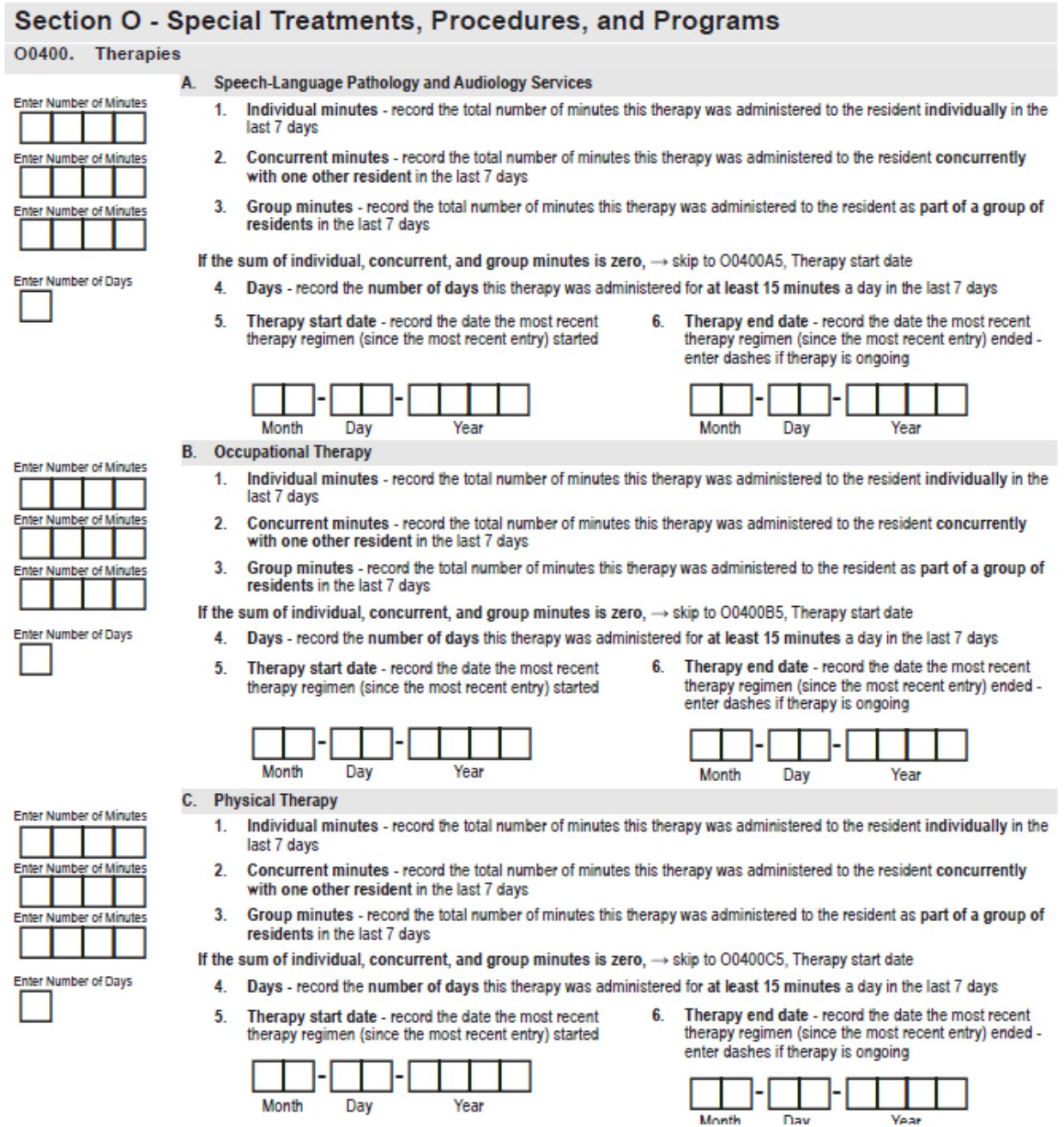
O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed while NOT a resident of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident.**
   Performed while a resident of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	[redacted]	☐
Other		
Z. None of the above	☐	☐

Section O Special Treatments, Procedures, Programs



Section O - Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month - Day - Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month - Day - Year

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month - Day - Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month - Day - Year

C. Physical Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month - Day - Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month - Day - Year

Section O Special Treatments, Procedures, Programs

Section O - Special Treatments, Procedures, and Programs

O0420. Distinct Calendar Days of Therapy

Enter Number of Days ☐☐

Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

O0450. Resumption of Therapy

Enter Code ☐

A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?

0. **No**
1. **Yes**

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐☐	A. Range of motion (passive)
☐☐	B. Range of motion (active)
☐☐	C. Splint or brace assistance
Number of Days	**Training and Skill Practice In:**
☐☐	D. Bed mobility
☐☐	E. Transfer
☐☐	F. Walking
☐☐	G. Dressing and/or grooming
☐☐	H. Eating and/or swallowing
☐☐	I. Amputation/prostheses care
☐☐	J. Communication

O0600. Physician Examinations

Enter Days ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Section O: Special Treatments, Procedures, and Programs

- Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

O0100: Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff.
- Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

Section O
Special Treatments, Procedures, and Programs

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 1

Check all treatments, procedures, and programs received or performed by the resident **prior** to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, **check Z, none of the above**.

Coding Instructions for Column 2

Check all treatments, procedures, and programs received or performed by the resident **after** admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips

• Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0100A Chemotherapy

- Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item.
- Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment.
  - For example, megestrol acetate is classified as an antineoplastic drug. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item.
  - Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.
- IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O0100I (Transfusions).

O0100 Coding Tips

- B. Radiation: Includes intermittent radiation therapy, as well as radiation administered via radiation implant.
- C. Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item.
- D. Suctioning: Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.
- E. Tracheostomy care: Code cleansing of the stoma, tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

O0100F Invasive Mechanical Ventilator

- Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support his or her own respiration in this item. During invasive mechanical ventilation, the resident's breathing is controlled by the ventilator.
- A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here.
- Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

O0100G Non-Invasive Mechanical Ventilator (BiPAP/CPAP)

- Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual.
- If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

O0100H IV Medications

- Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item.
- Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently, and they involve continuous administration of a substance.
- Do not code flushes to keep an IV access port patent, or IV fluids without medication here. Subcutaneous pumps are not coded in this item.
- Do not include IV medications of any kind that were administered during dialysis or chemotherapy.
- Dextrose 50% and/or Lactated Ringers given IV are not considered medications and should not be coded here.

O0100 Coding Tips (continued)

- I. Transfusions: Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.
- J. Dialysis: Code peritoneal or renal dialysis which occurs at the nursing home or at another facility.
- K. Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

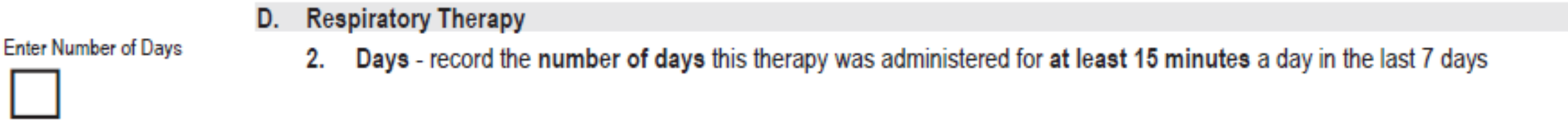
O0100M Isolation or Quarantine for Active Infectious Disease

- Code only when the resident requires transmission-based precautions
  - Is alone in a separate room
  - Has an active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage)
  - Highly transmissible or significant pathogens that have been acquired by physical contact, airborne, or droplet transmission.
- Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms).
- Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone.

Code for “single room isolation” only when all of the following conditions are met:

- 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
- 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
- 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

O0400D: Respiratory Therapy



- Respiratory Therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.
- **See Appendix A- Glossary page A-20, Pages O-23 and O-35 for more information**

Respiratory Therapy continued

- Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

O0420 Distinct Calendar Days of Therapy

- Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420.
- Examples start on RAI page O-33

Physician Examinations
Physician Orders

O0600. Physician Examinations

Enter Days

☐☐ Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days

☐☐ Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

O0600: Physician Exams and O0700: Physician Orders

- CMS does not require completion of this item; however, North Carolina continues to require its completion.
- Do not include exams prior to admission, ER visits, medicine men, or psychologists (O0400E)
- Examinations (full or partial) can occur in the facility or in the physician's office.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.

Physician Exams

Does require:

• Evidence of an examination by the physician or other licensed professional allowable by state law.

Does include:

• Partial or full examination in the facility, in the physician's office or off-site, e.g., while undergoing dialysis.

• Telehealth visits.

Medical Doctors, Doctors of osteopathy, Podiatrists, Dentists, authorized Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists working in collaboration with the physician.

Does NOT include:

• Examinations conducted prior to admission or reentry.

• Examinations conducted during an ER visit or hospital observation stay.

• Examination by a Medicine Man or Psychologist (PhD).

Physician Orders

Does include:

• Written, telephone, fax, or consultation orders for new or altered treatment.

• Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

Does NOT include:

• Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes.

• Orders written prior to admission or reentry.

• Activation of a PRN order already on file.

• Administration of different dosages from an established sliding scale.

• Monthly Medicare certification/recertification.

• Orders to increase the RUG classification.

• Orders written by a pharmacist.

• Orders for transfer of care to another physician.

Physician Exams

O0600. Physician Examinations

Enter Days

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician examinations can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- **Frequency** of **physician examinations can be an indication of medical complexity and** stability **of the resident's health status.**

Steps for Assessment

1. **Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.**

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).
- If the State does not require the completion of this item, use the standard "no information" code (a dash, "-").

OSA Section X

Section X - Correction Request

Complete Section X only if A0050 = 2 or 3

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider (A0200 on existing record to be modified/inactivated)

Enter Code ☐ **Type of provider**
1. **Nursing home (SNF/NF)**

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender (A0800 on existing record to be modified/inactivated)

Enter Code ☐
1. **Male**
2. **Female**

X0400. Birth Date (A0900 on existing record to be modified/inactivated)

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

X0500. Social Security Number (A0600A on existing record to be modified/inactivated)

☐☐☐ - ☐☐ - ☐☐☐☐

X0570. Optional State Assessment (A0300A/B on existing record to be modified/inactivated)

Enter Code ☐ A. **Is this assessment for state payment purposes only?**
0. **No**
1. **Yes**

Enter Code ☐ B. **Assessment type**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

X0700. Date on existing record to be modified/inactivated

A. **Assessment Reference Date** (A2300 on existing record to be modified/inactivated)

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Section X - Correction Request

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐ **Enter the number of correction requests to modify/inactivate the existing record, including the present one**

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ **Check all that apply**

☐ A. **Transcription error**
☐ B. **Data entry error**
☐ C. **Software product error**
☐ D. **Item coding error**
☐ Z. **Other error requiring modification**
If "Other" checked, please specify:

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)

↓ **Check all that apply**

☐ A. **Event did not occur**
☐ Z. **Other error requiring inactivation**
If "Other" checked, please specify:

X1100. RN Assessment Coordinator Attestation of Completion

A. **Attesting individual's first name:** ☐☐☐☐☐☐☐☐☐☐☐☐

B. **Attesting individual's last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

C. **Attesting individual's title:**

D. **Signature**

E. **Attestation date**

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Section Z: Assessment Administration

- The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.
- Rational: Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

OSA Section Z

Section Z - Assessment Administration

Z0200. State Medicaid Billing (if required by the state)

A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐

B. Version code: ☐☐☐☐☐☐☐☐☐☐

Enter Code ☐ C. Is this a Short Stay assessment?
0. No
1. Yes

Z0250. Alternate State Medicaid Billing (if required by the state)

A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐

B. Version code: ☐☐☐☐☐☐☐☐☐☐

Z0300. Insurance Billing

A. Billing code: ☐☐☐☐☐☐☐☐☐☐

B. Billing version: ☐☐☐☐☐☐☐☐☐☐

Section Z - Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature	Title	Sections	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature: _____

B. Date RN Assessment Coordinator signed assessment as complete: ☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Section Z - Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed